

# HIV Medical Case Management

Presented by:  
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## Break the Ice



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## Objectives

- Learn why medical case management is important for PLWH/A
- Define a Medical Case Manager as it relates to the Ryan White Programs
- Understand the difference between a medical and non-medical case manager
- Identify the core components of a medical case manager
- Discuss the tools to assist the medical case manager
- Address two complex cases from a MCM perspective

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## A little bit about us and where we come from...

- The grass is always Blue...



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## Bluegrass Care Clinic

- The BCC is located in the University of Kentucky Chandler Medical Center (UKCMC), providing services to persons living with HIV/AIDS (PLWHA) since 1990
- Funding
  - Ryan White Part C: HIV Early Intervention Services
  - Ryan White Part B & State Funds: HIV Care Coordinator Program
  - AIDS Education and Training Center (AETC)

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## Bluegrass Care Clinic

- Provides HIV services to 786 (2006) persons living with HIV/AIDS (PLWHs)
  - 6 Infectious Disease Specialty Physicians
  - 2 Primary Care Physicians
  - 2 Clinical Pharmacists
  - 1 Physician's Assistant
  - 1 Licensed Clinical Social Worker
  - 5 Social Worker Case Managers
- 50% of patients from rural area

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## Epidemiology

### Kentucky AIDS Cases (2006)

- Low prevalence compared to other states (ranks 36 with rate of 4.9/100,000)
- Cases mainly concentrated in Louisville 46% and Lexington 19%, Northern Kentucky 8%
- Largest number of cases in male gender (84%), MSM risk factor (55% - down from 65% in 2002), followed by IDU(13%)
- 10% of cases have undetermined etiologies: hemophilia, blood transfusions, and risks not identified or reported through heterosexual ct.

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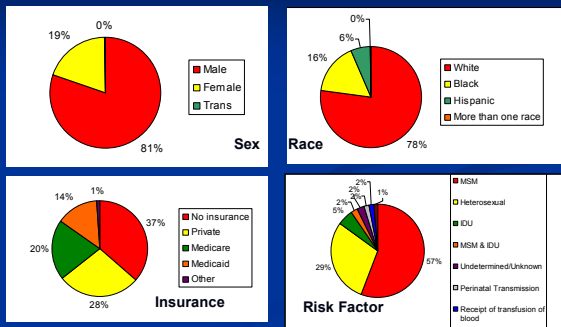
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## Bluegrass Care Clinic Demographics 2007




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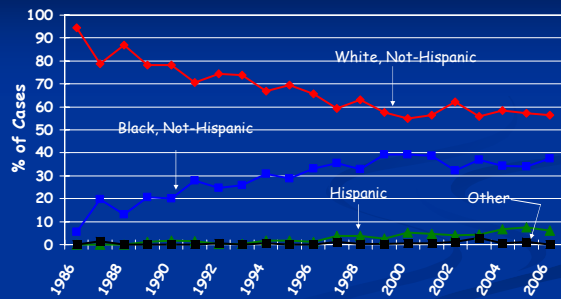
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## Kentucky AIDS Cases by Race/Ethnicity




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## BCC New Patient Demographics 118 New Patients in 2007 (%)

- The percentage of new ...
  - Hispanic Patients presenting to care has increased from 5% (2006) to 8% (2007)
  - Patients presenting in the 20-29 age category has increased from 10% (2002) to 25% (2007)
  - Patients presenting with heterosexual risk factor has increased from 28% (2001) to 31% (2006) – has been as high as 38-39% (2003-2004)

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## BCC New Patient Demographics

- The percentage of new “White Female” patients presenting to care has increased from 9% (2002) of the new patient population to 14% (2007)
- Conversely the percentage of new “White Males” presenting to care has decreased from 67% (2002) to 58% (2007)

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## Why Medical Case Management?

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## Patient Years Since Diagnosis

- Patients are continuing to live normal life spans presenting challenging care for physicians – managing both HIV as well as other co-morbidities
- 46% of the patient population has had HIV for at least 10 years
- Increased life expectancies due to medication management/adherence

\* Out of 647 patients

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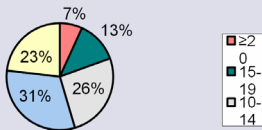
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BCC Years Since Diagnosis (2006)



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## AIDS Patients Face Downside of Living Longer

By [JANE GROSS](#)  
Published: January 6, 2008

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## HRSA Definition

Medical case management services are a range of *client-centered services* that link clients with:

- Health Care
- Psychosocial
- Other services

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## Other definitions

- Medical Model of Care
  - Physician assessment/prescription
- Disease Management Approach
  - Multi-disciplinary Treatment Teams
  - Evidence-based, Standardized Clinical Practices
  - Evaluation of Outcomes
- Fennel Four Phase Model of Chronic Illness\*
  - 1) Crisis 2) Stabilization 3) Resolution 4) Integration

\*Fennell, P. A. (2003). *Managing Chronic Illness: The Four Phase Approach*. New York: Wiley.

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## Medical Case Management

Seeks to ensure that persons living with HIV/AIDS are *enrolled* and *sustained* in *coordinated health care* for HIV disease that optimizes their health and well-being

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## Continuity of Care

### Assessment

- Client's and other key family members' needs
- Personal support systems

### Treatment Adherence Counseling

- Ensure *readiness & adherence* for complex HIV/AIDS treatments

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## Coordination

- Includes the *coordination* and *follow-up* of medical treatments
- Ensures timely and coordinated access to medically appropriate levels of health and support services

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## MCM Primary Activities

- Assist accessing health insurance/medical treatment payment programs –Medicaid, Medicare, COBRA
- Assist accessing primary and HIV-specific medical care, including HIV medications-KADAP, PAP
- Assistance with the *screening, assessment, referral* and appropriate *intervention* for:
  - oral health care- Dentistry-Ryan White Funding
  - medical nutritional services
  - mental health services
  - outpatient substance abuse treatment

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## Secondary Activities

- Housing assistance
- Medical transportation
- Food and nutrition
- Linguistic/translation services
- Evidence based practice
  - Ashman, J.J. et al. (2002) found that HIV-positive individuals who had these case management services were more likely to receive and be retained in primary care from a safety net provider

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## Medical MCM Knowledge Base

- Drug Side Effects and Adherence
- Opportunistic Infections
- Sexually Transmitted Disease
- MH and SA Signs and Symptoms
- Knowledge of Community Resources
- Knowledge of State Medicare, Medicaid, ADAP and Health Insurance Programs

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## Core MCM Components

- Intake
- Assessment
- Reassessment
- Care Planning
- Referral and Advocacy
- Follow-up and Monitoring
- Transfer and Inactivation
- Evaluation of Client Satisfaction

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## Key Activities

1. Initial assessment of service needs
2. Development of a comprehensive, individualized service plan
3. Coordination of services required to implement the plan
4. Client monitoring to assess the efficacy of the plan and consult with client for revision

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## Assessment Tools

- Medical History
  - Medication Adherence Assessment
  - Social History / Supports
  - Substance Abuse / Addiction Screening
  - Psychiatric / Mental Health History
  - Risk Assessment / Harm Reduction
- The state does not have a mandatory assessment tool; however, the BCC uses one

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## Care Plan Development & Training

### QUESTIONS TO CONSIDER

- What are the problems getting in your way right now?
- How do you think these problems can be resolved?
- What resources do you have for solving these problems?
- Which problems would you most like help with right now?

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**INDIVIDUALIZED CARE PLAN**

**LONG TERM GOAL:** \_\_\_\_\_

**SERVICE NEEDS:** (Circle those that apply.)

1. Economics/Budgeting	8. Health Care	15. Transportation
2. Shelter/Utilities	9. Assistance Devices/DME	16. Protective Issues
3. Medicine	10. Home Health Care	17. Employment
4. Interpreter/Relay	11. Education/Training	18. Medical Coverage
5. Legal Referral	12. Support Group	19. Emotional Support
6. Nutrition	13. Mental Health Referral	20. General Information
7. Sexual Risk Reduction	14. Substance Abuse Treatment	

USE ABOVE CIRCLED NEEDS AND LONG TERM GOAL TO COMPLETE THE NEXT PORTION

Short Term Goal: \_\_\_\_\_

BARRIERS TO OVERCOME IN ORDER TO ACCOMPLISH GOAL: \_\_\_\_\_

Tasks to Achieve Goal:

	Person to do Task	Date to be Done	Date Complete
1.			
2.			
3.			
4.			

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**Ongoing Monitoring & Assessment**

- Kentucky's standard is two contacts yearly with at least 1 face to face yearly
- Recertification must be completed yearly which includes evaluation of Care Plan

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**Client Satisfaction Survey  
Program Evaluation**

- Simple One Page Format
- Scale Format (Strongly Agree to Strongly Disagree)
- Mailed with Pre-Paid Addressed Envelope  
45% return rate in 2007

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1. I like the services that I receive.
2. If I had other choices, I would still get service from this agency.
3. I am treated with respect.
4. Staff is willing to see me as often as necessary.
5. Staff returns my phone calls in a timely manner.
6. Services are available at times that are good for me.
7. Staff here believes that I can meet my goals.
8. I understand what case management services are available to me.
9. I feel comfortable seeking resources for my medical care and medications.
10. I understand there is a grievance process, if needed.
11. Staff respects my confidentiality.
12. I receive education on how to reduce risky behaviors.
13. I have input into the development of my goals with my Care Coordinator.
14. Staff is sensitive to my cultural background (race, religion)
15. Staff helps me obtain the information I need so that I can take charge of managing my illness.
16. What are three things you like about this program?
17. What are three ways you think the Care Coordinator Program could be improved?

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## Case Studies

- We are presenting two case studies

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## Ms. Elizabeth

- 63 year old African American woman
- Diagnosed in November 2001 with AIDS
- CD4 count 67; Viral Load 50,230
- PCP
- Drug Naïve
- History of obesity, hypertension, increased cholesterol, and gout

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## Initial Assessment

- Client moved to Lexington from a small town in KY
- Divorced
- Drawing on her retirement
- No health insurance
- Discharge Planning –Referred to Care Coordinator Program and BBC

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## Social Support

- Teenaged grandson lived with client
- Daughter moved in once the client was hospitalized
- Other family members and friends
- HIV Women's support group

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## MH/SA History

- The client had no mental health history
- The client claimed no substance abuse history
- Client had stopped smoking several years earlier

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## On-going Case Management

- Adherence to Medication
- Other Health Issues
- Medicaid, SSI
- KADAP and PAP, CCP
- Transportation
- Housing Assistance-HOPWA-Section-8
- Hospital, Nursing Home and Hospital Admission

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## Case Study of Jose

- 42 year old native of El Salvador
- Diagnosed in November 2002 with AIDS
- CD4 count of 40; VL > 750,000
- Candidiasis
- Drug Naive
- History of alcohol abuse and seizure disorder

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## Initial Assessment

- Working prior to being hospitalized in local hospital
- In US 12 years at time of diagnosis
- Partner of 5 years HIV negative
- Diagnosed with AIDS as an inpatient
- Discharge Planning- Referred to BCC for treatment of HIV/AIDS

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## Action Steps

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## Social Support

- Partner active in care and is now P.O.A.
- Isolated due to language barrier--local church source of support
- Resident of Solomon House
- Hospice services while off ARV

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## MH / SA History

- Depression
- Alcohol abuse--recurrent pancreatitis
- Counseling – Meeting with therapist-report of conscription as teen guerilla-- PTSD
- Assessment for Substance Use/Abuse
- Partner referred to ALanon

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## Ongoing Case Management

- Adherence to Medications
- Mental Health Status
- Keep Medical Appointments/Labs
- Social Support – Has not seen family in many years
- Stable Housing

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## Collaboration with Medical Care Providers to Meet Client Goals

- Providers meet regularly with the case manager to discuss client's adherence with medical appointments and medication adherence
- Provider contacts the case manager when the client misses medical appointments
- Provider contacts the case manager when the client reports a need such as housing or transportation
- Provider refers client for case management based on client need

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## Collaboration with Medical Care Providers Continued

- Case manager contacts the provider to discuss any barriers that prevent the client from keeping medical appointments
- Case manager contacts the provider to discuss any barriers the client has regarding medication adherence
- Case manager follows up with the provider regarding any client needs reported by the provider
- Case manager follows up with the provider regarding case management referrals

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## Questions? Comments? Concerns?

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## Thank you for your time!

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